		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042044

Facility Name: Washington Heights N. H.

Address: 1010 West 95Th St . (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 298-1177 **Fax #** (773) 298-1666

IDPA ID Number: 364100431001

Date of Initial License for Current Owners: 10/24/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	228	Skilled (SNF)	228	83,448	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	228	TOTALS	228	83,448	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,660	276	7,748	13,684	8
9	SNF/PED					9
10	ICF	57,225	2,790	558	60,573	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,885	3,066	8,306	74,257	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.99%

D. How many bed-hold days during this year were paid by Public Aid? 59 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/24/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/24/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 228 and days of care provided 7,693

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	343,114	76,906	21,293	441,313		441,313	(11,137)	430,176			1
2	Food Purchase		326,945		326,945	(41,175)	285,770	5,612	291,382			2
3	Housekeeping	209,506	47,288		256,794		256,794	(7,648)	249,146			3
4	Laundry	100,168	42,445		142,613		142,613		142,613			4
5	Heat and Other Utilities			280,719	280,719		280,719	(11,399)	269,320			5
6	Maintenance	80,378	180	228,646	309,204		309,204	502	309,706			6
7	Other (specify):*							2,938	2,938			7
8	**TOTAL General Services**	733,166	493,764	530,658	1,757,588	(41,175)	1,716,413	(21,132)	1,695,281			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,142,892	94,730	152,445	3,390,067		3,390,067	11,478	3,401,545			10
10a	Therapy	124,642		1,920	126,562		126,562	(19)	126,543			10a
11	Activities	169,504	11,869	2,704	184,077		184,077		184,077			11
12	Social Services	146,460	125	5,478	152,063		152,063	13,349	165,412			12
13	Nurse Aide Training											13
14	Program Transportation			999	999		999		999			14
15	Other (specify):*							7,073	7,073			15
16	**TOTAL Health Care and Programs**	3,583,498	106,724	175,546	3,865,768		3,865,768	31,881	3,897,649			16
	C. General Administration											
17	Administrative	138,692		40,081	178,773		178,773	(6,919)	171,854			17
18	Directors Fees											18
19	Professional Services			396,765	396,765	(8,898)	387,867	(308,061)	79,806			19
20	Dues, Fees, Subscriptions & Promotions			73,601	73,601		73,601	(29,059)	44,542			20
21	Clerical & General Office Expenses	85,195	27,073	380,543	492,811		492,811	(121,720)	371,091			21
22	Employee Benefits & Payroll Taxes			809,534	809,534	41,175	850,709	(9,987)	840,722			22
23	Inservice Training & Education			638	638		638		638			23
24	Travel and Seminar			2,015	2,015		2,015	5,025	7,040			24
25	Other Admin. Staff Transportation			11,608	11,608		11,608	(9,516)	2,092			25
26	Insurance-Prop.Liab.Malpractice			219,302	219,302		219,302	1,091	220,393			26
27	Other (specify):*							32,382	32,382			27
28	**TOTAL General Administration**	223,887	27,073	1,934,087	2,185,047	32,277	2,217,324	(446,764)	1,770,560			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,540,551	627,561	2,640,291	7,808,403	(8,898)	7,799,505	(436,014)	7,363,491			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington Heights N. H. #0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			97,089	97,089		97,089	329,672	426,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,517	53,517		53,517	569,301	622,818			32
33	Real Estate Taxes			276,831	276,831	8,898	285,729	2,293	288,022			33
34	Rent-Facility & Grounds			1,266,222	1,266,222		1,266,222	(1,259,969)	6,253			34
35	Rent-Equipment & Vehicles			4,562	4,562		4,562	2,235	6,797			35
36	Other (specify):*			3,855	3,855		3,855		3,855			36
37	**TOTAL Ownership**			1,702,076	1,702,076	8,898	1,710,974	(356,468)	1,354,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		434,560	357,289	791,849		791,849	(29,348)	762,501			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,172	125,172		125,172		125,172			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		434,560	482,461	917,021		917,021	(29,348)	887,673			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,540,551	1,062,121	4,824,828	10,427,500		10,427,500	(821,830)	9,605,670			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	63,178	30		9
10	Interest and Other Investment Income	(284,277)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(132)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(19,358)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(108,000)	21		24
25	Fund Raising, Advertising and Promotional	(7,548)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,934)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(235,226)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (596,297)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(225,533)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (225,533)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (821,830)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Washington Heights N. H.

ID# 0042044

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (99)	21	1
2	Jury Duty	(69)	21	2
3	Patient Clothing	(22)	10	3
4	Theft Loss	(1,127)	21	4
5	Collection Expense	(327)	21	5
6	COPE Dues	(3,627)	20	6
7	Building Co Filing Fees	(250)	20	7
8	Amortization (Bldg Co Loan Fees)	(12,723)	36	8
9	Municipal Code Violations	(550)	20	9
10	PPA - Electricity Expense	(13,255)	05	10
11	Non-Allowable Legal	(872)	19	11
12	Capitalized R&M	(8,018)	06	12
13	NonAllowable Expense	(170,287)	21	13
14	Management Fees	(24,000)	17	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(235,226)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(318)	487		(3,891)	(7,415)				(11,137)	1
2	Food Purchase	(132)			(33)				5,777				5,612	2
3	Housekeeping				(7,648)								(7,648)	3
4	Laundry													4
5	Heat and Other Utilities	(13,255)				1,856							(11,399)	5
6	Maintenance	(8,018)			(107)	1,982		6,611	34				502	6
7	Other (specify):*						865	1,615	458				2,938	7
8	**TOTAL General Services**	(21,405)			(8,106)	4,325	865	4,335	(1,146)				(21,132)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(22)			(11,603)			23,103					11,478	10
10a	Therapy				(19)								(19)	10a
11	Activities													11
12	Social Services							13,349					13,349	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						1,740	5,333					7,073	15
16	**TOTAL Health Care and Programs**	(22)			(11,622)		1,740	41,785					31,881	16
	C. General Administration													
17	Administrative	(24,000)						16,857	224				(6,919)	17
18	Directors Fees													18
19	Professional Services	(872)				(307,212)			23				(308,061)	19
20	Fees, Subscriptions & Promotions	(11,975)	250			(17,347)			13				(29,059)	20
21	Clerical & General Office Expenses	(304,201)				18,102		163,975	404				(121,720)	21
22	Employee Benefits & Payroll Taxes			(424)	(592)		(8,971)						(9,987)	22
23	Inservice Training & Education													23
24	Travel and Seminar					4,925			100				5,025	24
25	Other Admin. Staff Transportation					(9,516)							(9,516)	25
26	Insurance-Prop.Liab.Malpractice					1,005			86				1,091	26
27	Other (specify):*						6,145	26,237					32,382	27
28	**TOTAL General Administration**	(341,048)	250	(424)	(592)	(310,043)	(2,826)	207,069	850				(446,764)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(362,475)	250	(424)	(20,319)	(305,718)	(221)	253,189	(296)				(436,014)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Heights N. H. # 0042044 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	63,178	242,970			18,401				5,123			329,672	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(284,277)	852,993						13	572			569,301	32
33	Real Estate Taxes					2,293							2,293	33
34	Rent-Facility & Grounds		(1,266,222)			5,787			466				(1,259,969)	34
35	Rent-Equipment & Vehicles					2,225			10				2,235	35
36	Other (specify):*	(12,723)	12,723											36
37	**TOTAL Ownership**	(233,822)	(157,536)			28,706			489	5,695			(356,468)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(14,516)				(4,232)	(10,600)			(29,348)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**				(14,516)				(4,232)	(10,600)			(29,348)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(596,297)	(157,286)	(424)	(34,835)	(277,012)	(221)	253,189	(4,039)	(4,905)			(821,830)	45

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Washington Heights Property, LLC	Building Co	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,266,222	Washington Heights Property LLC	100.00%	$	$ (1,266,222)	1
2	V	32	Interest Income/Expense	53,597	Washington Heights Property LLC	100.00%	906,590	852,993	2
3	V	20	Filing Fees		Washington Heights Property LLC	100.00%	250	250	3
4	V	30	Depreciation Expense		Washington Heights Property LLC	100.00%	242,970	242,970	4
5	V	36	Amortization Expense		Washington Heights Property LLC	100.00%	12,723	12,723	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,319,819			$ 1,162,533	$ * (157,286)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 78,040	$ 78,040	15
16	V									16
17	V									17
18	V									18
19	V		22	EMPLOYEE HEALTH INSURANCE	78,464	CCS EMPLOYEE BENEFIT GROUP	100.00%		(78,464)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 78,464			$ 78,040	$ * (424)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 318	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$ (318)	15
16	V	02	FOOD	222	XCEL MEDICAL SUPPLY, LLC	100.00%	189	(33)	16
17	V	03	HOUSEKEEPING	51,548	XCEL MEDICAL SUPPLY, LLC	100.00%	43,900	(7,648)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	721	XCEL MEDICAL SUPPLY, LLC	100.00%	614	(107)	19
20	V	10	NURSING	78,210	XCEL MEDICAL SUPPLY, LLC	100.00%	66,607	(11,603)	20
21	V	10A	THERAPY	126	XCEL MEDICAL SUPPLY, LLC	100.00%	107	(19)	21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	3,987	XCEL MEDICAL SUPPLY, LLC	100.00%	3,396	(592)	24
25	V	39	ANCILLARY	97,843	XCEL MEDICAL SUPPLY, LLC	100.00%	83,327	(14,516)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 232,974			$ 198,139	$ * (34,835)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 487	$ 487	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,856	1,856	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,982	1,982	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	317,205	Care Centers, Inc.	100.00%	9,993	(307,212)	20
21	V	20	Dues and Subscriptions	20,805	Care Centers, Inc.	100.00%	3,458	(17,347)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	18,102	18,102	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	4,925	4,925	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,005	1,005	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	18,401	18,401	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,293	2,293	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,787	5,787	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,225	2,225	29
30	V	25	Bus Reimbursement	9,516	Care Centers, Inc.	100.00%		(9,516)	30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 347,526			$ 70,514	$ * (277,012)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 5,909	Care Centers, Inc.	100.00%	$ 5,909	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	865	865	16
17	V	10	Nursing Salary	6,602	Care Centers, Inc.	100.00%	6,602		17
18	V	10a	Rehab Salary	1,920	Care Centers, Inc.	100.00%	1,920		18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	3,373	Care Centers, Inc.	100.00%	3,373		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,740	1,740	21
22	V	17	Administration Salary	6,368	Care Centers, Inc.	100.00%	6,368		22
23	V	21	Office Salary	35,635	Care Centers, Inc.	100.00%	35,635		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	6,145	6,145	24
25	V	22	Employee Benefits	8,971	Care Centers, Inc.	100.00%		(8,971)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 68,778			$ 68,557	$ * (221)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,322	Care Centers, Inc.	100.00%	$ 4,431	$ (3,891)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	6,611	6,611	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,615	1,615	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	23,103	23,103	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	13,349	13,349	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	5,333	5,333	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	16,857	16,857	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	163,975	163,975	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	26,237	26,237	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,322			$ 261,511	$ * 253,189	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 11,412	Care Centers, Inc. - Health Systems Division	100.00%	$ 868	$ (10,544)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	5,777	5,777	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	34	34	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	224	224	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	23	23	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	13	13	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	404	404	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	100	100	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	86	86	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	13	13	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	466	466	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	10	10	26
27	V	39	Ancillary Enteral Supplies	8,570	Care Centers, Inc. - Health Systems Division	100.00%	4,338	(4,232)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	3,129	3,129	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	458	458	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 19,982			$ 15,943	$ * (4,039)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 5,123	$ 5,123	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	572	572	16
17	V	39	Vent Reimbursement	10,600	Vent Lease, LLC.	100.00%		(10,600)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,600			$ 5,695	$ * (4,905)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Aronin	Owner	Administrative	0.89%	See Attached	1.97	3.51%	Alloc Salary	$ 4,514	17-7	1
2	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.56	3.38%	Mgmt Fee	9,713	17-3	2
3	Norm Goldberg	Owner	Administrative	1.77%	See Attached	3.00	6.00%	Alloc Salary	4,706	17-7	3
4	Mark Steinberg	Relative	Administrative	0.00%	See Attached	5.00	9.09%	Alloc Salary	3,024	17-7	4
5	Adam Vales	Relative	Clerical	5.75%	See Attached	0.51	1.28%	Alloc Salary	526	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,483		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 78,040	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 78,040	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation						189	2
3	03	HOUSEKEEPING	Direct Allocation						43,900	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						614	5
6	10	NURSING	Direct Allocation						66,607	6
7	10A	THERAPY	Direct Allocation						107	7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						3,396	10
11	39	ANCILLARY	Direct Allocation						83,327	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 198,139	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	74,257	$ 487	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		74,257	1,856	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		74,257	1,982	3
4	10	Nursing	Patient Days	1,484,397	42			74,257		4
5	11	Activities	Patient Days	1,484,397	42			74,257		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		74,257	9,993	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		74,257	3,458	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		74,257	18,102	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		74,257	4,925	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		74,257	1,005	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		74,257	18,401	11
12	32	Interest	Patient Days	1,484,397	42			74,257		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		74,257	2,293	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		74,257	5,787	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		74,257	2,225	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 70,514	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		5,909	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			865	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		6,602	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982		1,920	4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710		3,373	6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			1,740	7
8	17	Administration Salary	Direct Cost			38,431	38,431		6,368	8
9	21	Office Salary	Direct Cost			525,935	525,935		35,635	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			6,145	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 68,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	74,257	4,431	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			74,257		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	74,257	6,611	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		74,257	1,615	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	74,257	23,103	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			74,257		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	74,257	13,349	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		74,257	5,333	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	74,257	16,857	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	74,257	163,975	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		74,257	26,237	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 261,511	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		19,982	868	1
2	02	Food	Billable Income	2,144,835		987,169		19,982	5,777	2
3	06	Maintenance	Billable Income	2,144,835		3,597		19,982	34	3
4	17	Administration	Billable Income	2,144,835		24,000		19,982	224	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		19,982	23	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		19,982	13	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		19,982	404	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		19,982	100	8
9	26	Insurance	Billable Income	2,144,835		9,262		19,982	86	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		19,982	13	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		19,982	466	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		19,982	10	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		19,982	4,338	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	19,982	3,129	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		19,982	458	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 15,943	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	10,600	$ 5,123	1
2	32	Interest	Direct Billing	620,670	29	33,493		10,600	572	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 5,695	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X	Mortgage			$	$ 11,729,516			$ 906,590	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Building Company		X	Working Capital							53,517	6
7	Allocate Care Centers		X								13	7
8	See Supplemental Schedule										572	8
9	TOTAL Facility Related						$	$ 11,729,516			$ 960,692	9
	B. Non-Facility Related*											
10	Interest Income		X								(284,277)	10
11	Interest Income - Bldg Co	X									(53,597)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (337,874)	14
15	TOTALS (line 9+line14)						$	$ 11,729,516			$ 622,818	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocate Vent Lease		X				$	$			$ 572	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										572	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	368,016	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	316,854	2
3. Under or (over) accrual (line 2 minus line 1).	$	(51,162)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	330,286	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	8,898	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	288,022	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	353,852	8
	2000	337,917	9
	2001	346,759	10
	2002	350,493	11
	2003	314,561	12

2004 Accrual = $314,561 X 1.05 = $330,286

Care Centers Allocation - $2,293

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Heights N. H. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-001-0000	Long Term Care Property	$ 1,170.14	$ 1,170.14
2.	25-05-423-002-0000	Long Term Care Property	$ 1,291.46	$ 1,291.46
3.	25-05-423-003-0000	Long Term Care Property	$ 1,476.20	$ 1,476.20
4.	25-05-423-004-0000	Long Term Care Property	$ 1,430.69	$ 1,430.69
5.	25-05-423-005-0000	Long Term Care Property	$ 7,561.03	$ 7,561.03
6.	25-05-423-006-0000	Long Term Care Property	$ 38,764.57	$ 38,764.57
7.	25-05-423-007-0000	Long Term Care Property	$ 46,748.65	$ 46,748.65
8.	25-05-423-008-0000	Long Term Care Property	$ 120,770.06	$ 120,770.06
9.	25-05-423-009-0000	Long Term Care Property	$ 95,348.20	$ 95,348.20
10.	Care Centers Allocation	Home Office	$ 106,873.39	$ 2,293.05
		TOTALS	$ 421,434.39	$ 316,854.05

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Heights N. H. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior Brick Frame Masonry/Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	85,244	1994	$ 251,898	1
2	Allocation From 2201 Main, LLC			17,594	2
3	TOTALS	85,244		$ 269,492	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	21,522		20	1,077	1,077	9,103	9
10	Various			1997	179,381		20	8,971	8,971	66,857	10
11	Various			1998	71,893		20	3,596	3,596	23,466	11
12	Various			1999	54,109		20	2,705	(2,705)	14,729	12
13	Various			2000	102,147		20	5,618	5,618	26,193	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		10,226,094	242,970		254,542	11,572	2,046,374	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		67,876	2,787		2,787		5,789	68
69	Financial Statement Depreciation			97,089			(97,089)		69
70	TOTAL (lines 4 thru 69)		$ 10,723,022	$ 342,846		$ 279,296	$ (68,960)	$ 2,192,511	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,723,022	$ 342,846		$ 279,296	$ (63,550)	$ 2,192,511	1
2	3Rd Floor Corridor	2001	11,766		20	588	588	2,353	2
3	Carpeting	2001	20,162		20	1,008	1,008	4,032	3
4	Pump	2001	1,175		20	59	59	235	4
5	Pump	2001	665		20	33	33	133	5
6	American Eagle Detec	2001	1,450		20	73	73	285	6
7	Hvac Repair	2001	887		20	44	44	173	7
8	Fire Alarm R&M	2001	2,282		20	114	114	447	8
9	Hot Water Heater	2001	6,520		20	326	326	1,250	9
10	American Eagle Detec	2001	1,450		20	73	73	279	10
11	Amer Edge Detector E	2001	1,450		20	73	73	273	11
12	Fence Repair	2001	562		20	28	28	103	12
13	Boiler R & M	2001	612		20	31	31	113	13
14	Hot Water Heater	2001	4,564		20	228	228	818	14
15	Hvac Repair	2001	767		20	38	38	137	15
16	Hvac Repair	2001	973		20	49	49	171	16
17	Plumbing R&M	2001	625		20	31	31	107	17
18	Inspect Underground	2001	798		20	40	40	133	18
19	Cleanout Sewer	2001	2,980		20	149	149	497	19
20	Backflow Service	2001	860		20	43	43	143	20
21	Paint	2001	690		20	35	35	110	21
22	Lift	2002	2,149		20	215	215	645	22
23	Stain Glass	2002	695		20	70	70	209	23
24	Basement Ramp Exit Door	2002	1,116		20	112	112	335	24
25	Patio Awning	2002	4,400		20	440	440	1,320	25
26	3Rd Floor Cafeteria Floor	2002	5,772		20	577	577	1,732	26
27	Repair On Sprinkler System	2002	1,233		20	247	247	740	27
28	Replace Pump	2002	1,562		20	312	312	937	28
29	Concrete Paving	2002	561		20	56	56	164	29
30	Roofing R&M	2002	950		20	95	95	277	30
31	A/C Repair	2002	506		20	101	101	295	31
32	A/C Repair	2002	816		20	163	163	476	32
33	Valve Repair	2002	844		20	169	169	492	33
34	TOTAL (lines 1 thru 33)		$ 10,804,864	$ 342,846		$ 284,916	$ (57,930)	$ 2,211,925	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,804,864	$ 342,846		$ 284,916	$ (57,930)	$ 2,211,925	1
2	A/C Repair	2002	585		20	117	117	341	2
3	A/C Repair	2002	870		20	174	174	508	3
4	A/C Repair	2002	684		20	137	137	399	4
5	R&M Fan Coil Units	2002	1,562		20	312	312	911	5
6	R&M Fan Coil Units	2002	863		20	173	173	503	6
7	A/C Repair	2002	506		20	101	101	295	7
8	A/C Repair	2002	863		20	173	173	475	8
9	Phone Jacks	2002	925		20	93	93	254	9
10	Phone Jacks	2002	925		20	93	93	247	10
11	A/C Repair	2002	546		20	109	109	282	11
12	Drapes	2002	932		20	93	93	241	12
13	R&M Fan Coil Units	2002	863		20	173	173	446	13
14	Carpeting	2002	29,566		20	2,957	2,957	7,392	14
15	R&M Fan Coil Units	2002	868		20	174	174	434	15
16	A/C Repair	2002	530		20	106	106	265	16
17	Plumbing R&M	2002	860		20	172	172	416	17
18	Flooring	2002	12,986		20	1,299	1,299	2,922	18
19	Sidewalk R&M	2002	1,820		20	182	182	410	19
20	Carpeting, Material, Labor & Tax	2002	4,381		20	438	438	986	20
21	Pipe R&M	2002	2,200		20	220	220	477	21
22	A/C Repair	2002	1,147		20	115	115	249	22
23	Draperies	2002	774		20	77	77	168	23
24	Crackfilling	2002	4,174		20	417	417	904	24
25	Ductwork	2002	1,740		20	174	174	377	25
26	Parkway Lighting	2002	744		20	74	74	161	26
27	Valve Repair	2002	781		20	156	156	338	27
28	Ceiling Tile	2003	585		20	59	59	117	28
29	Elevator Repair	2003	2,529		20	253	253	379	29
30	Exit Doors	2003	1,180		20	59	59	89	30
31	Elevator Doors	2004	3,187		20	159	159	159	31
32	Repair Elevator Door	2004	3,187		20	133	133	133	32
33	New Telephone System	2004	2,929		20	488	488	488	33
34	TOTAL (lines 1 thru 33)		$ 10,891,156	$ 342,846		$ 294,376	$ (48,470)	$ 2,233,691	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,891,156	$ 342,846		$ 294,376	$ (48,470)	$ 2,233,691	1
2	Midwest Mechanical	2004	575		20	48	48	48	2
3	New Telephone System	2004	2,670		20	445	445	445	3
4	Roof Repair	2004	1,200		20	60	60	60	4
5	Radio Controlled Doors	2004	4,763		20	198	198	198	5
6	Widen Driveway	2004	1,875		20	63	63	63	6
7	Widen Driveway	2004	2,000		20	67	67	67	7
8	Elevator Recall System	2004	2,200		20	37	37	37	8
9	Widen Driveway	2004	1,875		20	63	63	63	9
10	Back Lot Pavement	2004	2,685		20	90	90	90	10
11	Locks On Doors	2004	7,574		20	505	505	505	11
12	Piping & Wiring	2004	1,656		20	41	41	41	12
13	Lab To Remove Debris	2004	2,623		20	44	44	44	13
14	Repair Epdm Roof	2004	700		20	12	12	12	14
15	Fire Alarm System	2004	1,200		20	40	40	40	15
16	Elevator Recall System	2004	1,200		20	10	10	10	16
17	Lighting Maintenance	2004	578		20	5	5	5	17
18	Repair Epdm Roof	2004	650		20	5	5	5	18
19	Plumbing Maintenance	2004	1,300		20	11	11	11	19
20	Smoke Damper	2004	1,448		20	17	17	17	20
21	Zone Valve Thermostat	2004	1,020		20	17	17	17	21
22	Exhaust Fan	2004	1,223		20	20	20	20	22
23	Window Treatment Rods	2004	1,613		20	13	13	13	23
24	Hot Water Heater - Repair	2004	1,579		20	11	11	11	24
25	Hvac	2004	2,811		20	281	281	281	25
26	Repairs To Shower Rooms	2004	825		20	83	83	83	26
27	Hvac	2004	1,548		20	155	155	155	27
28	Pneumatic Thermostat And Installation	2004	1,117		20	112	112	112	28
29	Sprinkler Repairs	2004	556		20	28	28	28	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,942,220	$ 342,846		$ 296,856	$ (45,990)	$ 2,236,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996		$ 10,226,094	$ 242,970		$ 254,542	$ 11,572	$ 2,046,374	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,226,094	$ 242,970		$ 254,542	$ 11,572	$ 2,046,374	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main, LLC Allocation			2002	$ 24,245	$ 606		$ 606	$	$ 1,515	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main, LLC Allocation			2002	20,028	1,001	20	1,001		2,504	9
10	2201 Main, LLC Allocation			2003	23,603	1,180	20	1,180		1,770	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 67,876	$ 2,787		$ 2,787	$	$ 5,789	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 985,252	$ 10,947	$ 105,705	$ 94,758	10	$ 769,402	71
72	Current Year Purchases	103,464	7,227	21,637	14,410	10	21,637	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,088,716	$ 18,174	$ 127,342	$ 109,168		$ 791,039	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Centers Allocation	Allocated Care Centers		$ 34,169	$ 2,485	$ 2,485	$	5	$ 28,775	76
77	Care Centers Allocation	Allocated Care Centers		521	78	78		5	78	77
78										78
79										79
80	TOTALS			$ 34,690	$ 2,563	$ 2,563	$		$ 28,853	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,335,118	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 363,583	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 426,761	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 63,178	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,056,063	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocate Care Centers				6,253			5
6								6
7	TOTAL				$ 6,253 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 6,797 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 176,510	$		$ 176,510	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			14,939			14,939	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			154,703			154,703	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			11,137	236,868		248,005	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						197,692		197,692	13
14	TOTAL			$		$ 357,289	$ 434,560		$ 791,849	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,147	$ 131,942	1
2	Cash-Patient Deposits	63,594	63,594	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,567,081	2,897,370	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	302,387	302,387	6
7	Other Prepaid Expenses	15,118	15,118	7
8	Accounts Receivable (owners or related parties)	(992,302)	15,170	8
9	Other(specify): See Attached Schedule	3,486,313	3,486,313	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,448,338	$ 6,911,894	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,898	13
14	Buildings, at Historical Cost		8,473,923	14
15	Leasehold Improvements, at Historical Cost	535,191	970,255	15
16	Equipment, at Historical Cost	393,443	2,378,870	16
17	Accumulated Depreciation (book methods)	(513,734)	(4,533,961)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		48,456	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 414,900	$ 7,589,441	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,863,238	$ 14,501,335	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,292,917	$ 1,623,206	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,623	57,623	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,779	147,779	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,119	7,119	31
32	Accrued Real Estate Taxes(Sch.IX-B)	330,286	330,286	32
33	Accrued Interest Payable		76,024	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	36,985	42,097	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,872,709	$ 2,284,134	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,729,516	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,729,516	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,872,709	$ 14,013,650	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,990,529	$ 487,685	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,863,238	$ 14,501,335	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,019,247	1
2	Restatements (describe):		2
3	**Depreciation Adjustment**	(55,091)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,964,156	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	53,773	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(27,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 26,373	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,990,529	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,995,627	1
2	Discounts and Allowances for all Levels	(1,724,719)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,270,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,515,554	6
7	Oxygen	13,268	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,528,822	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	268,495	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	90,055	19
20	Radiology and X-Ray	4,380	20
21	Other Medical Services	34,142	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 397,072	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	284,277	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 284,277	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	194	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,481,273	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,757,588	31
32	Health Care	3,865,768	32
33	General Administration	2,185,047	33
	B. Capital Expense		
34	Ownership	1,702,076	34
	C. Ancillary Expense		
35	Special Cost Centers	791,849	35
36	Provider Participation Fee	125,172	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,427,500	40
41	**Income before Income Taxes (line 30 minus line 40)****	53,773	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 53,773	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,115	$ 74,086	$ 35.03	1
2	Assistant Director of Nursing	4,208	6,045	175,513	29.03	2
3	Registered Nurses	17,579	19,364	478,055	24.69	3
4	Licensed Practical Nurses	50,261	55,024	1,175,853	21.37	4
5	Nurse Aides & Orderlies	124,423	134,301	1,217,577	9.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,922	8,816	124,642	14.14	8
9	Activity Director	3,167	3,405	43,269	12.71	9
10	Activity Assistants	15,404	16,676	126,235	7.57	10
11	Social Service Workers	11,761	12,974	146,460	11.29	11
12	Dietician					12
13	Food Service Supervisor	3,249	3,971	57,360	14.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,953	35,589	285,754	8.03	15
16	Dishwashers					16
17	Maintenance Workers	5,577	6,218	80,378	12.93	17
18	Housekeepers	26,211	27,950	209,506	7.50	18
19	Laundry	12,665	13,435	100,168	7.46	19
20	Administrator	1,981	2,288	85,761	37.48	20
21	Assistant Administrator	2,440	2,611	52,931	20.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,248	8,902	85,195	9.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,816	2,014	21,808	10.83	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	331,881	361,698	$ 4,540,551 *	$ 12.55	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	301	$ 12,971	01-03	35
36	Medical Director	96	12,000	09-03	36
37	Medical Records Consultant	Monthly	2,763	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,475	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	2,704	11-03	44
45	Social Service Consultant	31	1,674	12-03	45
46	Other(specify)				46
47	Psycho Social Consultant	8	432	12-03	47
48	See Attached - CCI Consultant		20,216	Various	48
49	TOTAL (lines 35 - 48)	492	$ 55,235		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,577	$ 78,320	10-03	50
51	Licensed Practical Nurses	1,844	62,285	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,421	$ 140,605		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Curtis (5/11-12/31/04)	Administrator	0	$ 47,385
Scott Braun (1/1-12/31/04)	Administrator	0	26,042
David Berkowitz (1/1-6/18/04)	Administrator	0	22,078
Melody Parks (2/17-12/31/04)	Asst Admin	0	43,187
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 138,692

B. Administrative - Other

Description	Amount
Eric Rothner	$ 9,713
Alan Abrams-Adj. out on page 5a	12,000
Ron Abrams-Adj. out on page 5a	12,000
See Supplemetal Schedule	6,368
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 40,081

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers, Inc.	Home Office Expense	$ 191,520
Care Centers, Inc.	Ancillary Admin Expense	27,360
Care Centers, Inc.	Bookkeeping	46,512
Care Centers, Inc.	Accounting	15,000
FR&R	Accounting	18,000
Care Centers, Inc.	Data Processing	8,208
ADP	Data Processing	14,029
Personnel Planners	Unemployment Consult	4,156
Care Centers, Inc.	Other Professional	7,800
Legat Architects	Architect Fees	9,946
Morton Cohen	Pharmacy Mgmt Consult	5,360
See Supplemetal Schedule		48,875
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 396,766

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,221
Unemployment Compensation Insurance	104,676
FICA Taxes	342,800
Employee Health Insurance	192,323
Employee Meals	41,175
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	8,240
Employee Physicals	1,648
Pension Expense	34,096
Holiday Expense	4,328
Other Employee Welfare	8,215
TOTAL (agree to Schedule V, line 22, col.8)	$ 840,722

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 9,233
Advertising: Employee Recruitment	12,377
Health Care Worker Background Check	6,620
(Indicate # of checks performed 366)	
Licenses and Fees	7,107
Dues and Subscriptions	5,734
Allocate Care Centers	3,471
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,542

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,015
Allocate Care Centers	5,025
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,040

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington Heights N. H. # 0042044 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights N. H. **#** 0042044 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $8,116**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,403** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **125,172**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **41,175** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100 % Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.